OM 16-007
EFFECTIVE DATE: 18 March 2016

By Order of the Acting Assistant Director
Stewart D. Smith, DHSC/s/

TO: IHSC Commissioned Corps Officers, Civilian Federal Employees and Contract Personnel

SUBJECT: Mortality Review

A. Applicability. This Operations Memorandum (OM) applies to all IHSC personnel, including, but not limited to, Public Health Service (PHS) officers and federal employees supporting health care operations in ICE-owned, or contracted detention facilities, and to IHSC Headquarters (HQ) staff. This OM applies to contract personnel when supporting IHSC in detention facilities and at HQ.

B. General.

1. This Operations Memorandum (OM) replaces SOP 3.10.2 Mortality Notification, 3.10.2.1 Mortality Review & 3.10.2.2 Mortality Database, from the legacy DIHS Policy and Procedure Manual. This is the first issuance published under the new Policy and Procedure issuance system.

2. The guidance and accountability procedures described herein are effective immediately upon publication of this OM.

3. The directive and guide referenced in this OM, *Clinical Incident Management,* is currently in draft form and is forthcoming in 2015.

4. This OM is effective until rescinded or superseded by other applicable governing documents.

C. Overview. A clinical mortality review is conducted to determine the appropriateness of the clinical care provided and the effectiveness of the facility's policies and procedures relevant to the circumstances surrounding the death.

1. Generally, a clinical mortality review ascertains whether changes to policies, procedures or practices are warranted and identifies issues that require further study.

2. All deaths of detainees who die in ICE custody are reviewed by IHSC to determine whether the standard of care was met in relation to nationally recognized standards of care and practice, identification of areas of patient care or system policies and procedures that can be improved, was earlier intervention possible, and recommendations for corrective action.

   Exception: IHSC may not conduct a mortality review if the suspected manner of death is a homicide and access to relevant records and information is impeded due to an ongoing criminal investigation.

3. The mortality review is completed and findings are reported to designated ICE and Department of Homeland Security (DHS) offices and affected clinical staff within established time periods.

D. Scope of Mortality Review.

A mortality review consists of an administrative review, a clinical mortality review, and, if indicated, a psychological autopsy.

1. Administrative Review. An administrative review is an assessment of correctional and emergency response actions surrounding a detainee's death. Its purpose is to identify areas where facility operations, policies, and procedures can be improved.

2. Clinical Mortality Review. A clinical mortality review is an assessment of the clinical care provided and the circumstances leading up to the detainee's death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved.

3. Psychological Autopsy. A psychological autopsy is conducted if the death was by suicide. It is a written reconstruction of the detainee's life with an emphasis on factors that led up to and may have contributed to the detainee's death.

E. Roles and Responsibilities

1. The IHSC Deputy Assistant Director (DAD) of Clinical Services/Medical Director (DAD/MD), or designee, is responsible for:

   a. Authorizing a mortality review for all detainees who die while in ICE custody. At the AD/DAD/MD's discretion, a mortality review may be conducted for detainees recently released from ICE custody.

   b. Determining whether an IHSC Medical Quality Management Unit (MQMU), Compliance Investigator (CI) fact-finder should conduct an on-site investigation.

c. Authorizing the site visit investigation.

d. Determining whether a psychological autopsy is required. If required, assigning a psychologist or other qualified behavioral health professional to conduct a psychological autopsy.

e. Notifying the selected behavioral health professional to initiate a psychological autopsy, and whether an on-site investigation is authorized

f. Notifying the Chief of MQMU to initiate a mortality review.

g. Notifying the Chief of MQMU whether a psychological autopsy is required, and which behavioral health professional will conduct the review.

h. Participating in the scheduled mortality review committee meeting.

i. Assigning Department of Homeland Security (DHS) credentialed healthcare providers, from the same professional disciplines as the healthcare providers undergoing the review, as mortality review committee members. Recommending IHSC staff, based on the required discipline, to participate in the scheduled mortality peer review committee meeting.

j. Reviewing and approving the final mortality report.

2. The Chief of MQMU or designee is responsible for:

a. Assigning a CI as the lead fact-finder for the review.

b. Notifying the selected CI fact finder to initiate a mortality review, and whether an on-site investigation is authorized.

c. Notifying the Department of Homeland Security (DHS) Office of Health Affairs (OHA) of the death in accordance with DHS Instruction 248-01-001, Medical Quality Management, within 48 hours of death notification at (b)(7)(E) @hq.dhs.gov.

d. Notifying IHSC Health Information Management Systems (HIMS) Program Manager to request medical records and or related documents.

e. Ensuring the mortality review is completed within 30 business days after notification of death. If a mortality review is conducted for a detainee recently released from ICE custody, the review is required to be completed within 45 business days after the notification of death.

f. Disseminating final mortality report to OHA, Medical Quality Management at (b)(7)(E) @hq.dhs.gov.

g. Directing and supervising dissemination of the mortality review findings and implementation and monitoring of the mortality review recommendations.

h. Disseminating mortality review findings and implementation and monitoring of the mortality review recommendations for IHSC staffed detention facilities.

i. Disseminating to the Medical Case Management (MCM) Unit Chief the mortality review findings and implementation and monitoring of the mortality review recommendations for non-IHSC staffed detention facilities.

j. Facilitating the mortality review, as needed

3. The Compliance Investigator (CI) is responsible for:

a. Conducting a mortality review in accordance with IHSC Significant Event Peer Review directives and guidance, and the instructions in this OM.

b. Ensuring the death is investigated within 20 business days.

c. Gathering all relevant records, conducting interviews, conducting a site visit investigation if authorized, and preparing all required mortality review reports in accordance with all applicable IHSC investigation and peer review directives and guides (.01-11: Physician Peer Review; 01-14 Nurse Chart Audit; 01-27 Mid-Level Provider Peer Review; and 01-30 Behavioral Health Provider Peer Review)

d. Completing and submitting a preliminary report of findings to the DAD/MD and Chief of MQMU within 24 hours of notification of death. The 24 Hour Report of Natural Death, Suicide or Suicide Attempt, and the CIU fact-finder's reports are pre-decisional documents, intended for internal IHSC peer review discussion. These reports cannot be distributed to parties not expressly authorized to receive them in this OM without the IHSC Assistant Director's (AD) approval.

e. If applicable, coordinating/assisting fact-finding requests and site-visit investigation plans with the behavioral health professional conducting the psychological autopsy.

f. Ensuring all records and documents related to the mortality review and psychological autopsy are filed in accordance with the IHSC Significant Event Peer Review directives and guidance and the instructions outlined in this OM.

g. Scheduling and leading the mortality peer review committee process in collaboration with the IHSC Medical Director.

h. Granting access to the mortality review case file to applicable IHSC staff involved in the mortality review process.

i. Completing the final draft of the mortality review within 30 business days and forwarding it to the IHSC DAD-Medical Services and IHSC AD for approval and signature.

j. Disseminating reports and information related to the mortality review in accordance with the IHSC Clinical Incident Management directive and Guide.

4. The assigned HSA or FMC is responsible for:

a. Facilitating HIMS with medical records procurement, e.g. copies of the detainee's medical records (to include detention facility medical records, emergency medical services (EMS) reports, emergency department (ED) and hospitalization records)

b. Providing copies of employee written statements (memo of record) related to the circumstances surrounding the detainee's death to the designated CIU fact-finder. This memo should be requested and completed by all staff involved in the circumstances surrounding the detainee death, within 48 hours of the detainee death

c. Cooperating with all inquiries made by authorized fact-finders/reviewers and providing complete and accurate information related to the mortality review.

d. Providing copies of all relevant documents and information that may aid the investigation to the CIU fact-finder.

5. The behavioral health professional conducting the psychological autopsy is responsible for:

a. Coordinating fact finding requests and site-visit investigation plans with the assigned CI.

b. Ensuring the psychological autopsy is completed within 30 days of the detainee death notification.

c. Forwarding all records and documents used to compile the report to the Compliance Investigator fact-finder, for filing in the mortality review case file.

6. Staff assigned as IHSC Mortality Review Committee members are responsible for:

a. Reviewing all the relevant records and fact finder reports to determine the appropriateness of the clinical care provided; ascertaining whether changes to policies, procedures, or practices are warranted; and identifying issues that require further study.

b. Ensuring the information is not copied, disseminated, and/or filed in a manner not authorized by this OM.

c. Not distributing the mortality review report and psychological autopsy report to parties not expressly authorized to receive them in this OM without the Assistant Director's (AD) approval.

d. Maintaining confidentiality of the mortality review committee discussions/deliberations without the AD's approval.

e. Signing a confidentiality statement.

F. Procedures:

1. Notification and Reporting.

Reports of findings and supporting documents related to mortality reviews are disseminated in accordance with DHS, ICE, Enforcement and Removal Operations (ERO) and IHSC policies.

a. Within 24 hours after the detainee's death:

The DAD/MD, or designee:

- ✓ Notifies the Chief of MQMU to initiate a mortality review, and informs the Chief of MQMU whether an on-site investigation is authorized.

- ✓ Notifies the Chief of MQMU of which qualified behavioral health professional was selected to conduct a psychological autopsy (if indicated).

The Chief of MQMU, or designee:

- ✓ Selects and notifies a CI fact-finder to initiate a mortality review, and informs the CI whether an on-site investigation is authorized.

- ✓ Notifies OHA-MQM of the detainee death.

- ✓ Notifies IHSC Health Information Management Systems (HIMS) Program Manager to request medical records and or related documents

b. Within one business day after the detainee's death (or when records are received):

The affected HSA or FMC:

- ✓ Provides (or requests) copies of the detainee's medical records (to include detention facility medical records, EMS reports, ED and hospitalization records) and sends to the designated CIU fact-finder.

- ✓ Provides copies of employee written statements related to the circumstances surrounding the detainee's death to the designated CI fact-finder.

- ✓ Provides copies of all documents and information requested by the CI fact-finder.

- ✓ Provides copies of all relevant documents and information that may aid the investigation to the CI fact-finder.

The CI fact-finder:

- ✓ Creates a limited access case file in the MQMU "Mortality and SEN Review" SharePoint folder.

- ✓ Grants permanent access to the "Mortality and SEN Review" SharePoint folder to:

  i. The IHSC Assistant Director (AD), DAD/MD,

  ii. Associate MD,

  iii. Chief MQMU,

  iv. DAD for Administrative Services (DAD/AS),

v. MQMU Continuous Quality Improvement (CQI) Program Manager, and

vi. MQMU Risk Management Program Manager.

✓ Grants temporary access to the "Mortality and SEN Review" SharePoint folder to:

i. The Chief of Medical Case Management Unit (MCMU), if the detainee was in custody in a non-IHSC staffed detention facility.

ii. The behavioral health professional conducting the psychological autopsy.

iii. The selected peer reviewers.

iv. Any other IHSC personnel authorized by the AD, DAD/MD, or DAD/Administrative Services (DAD-AS)

✓ Immediately upon receipt, files the 24 Hour Report of Natural Death, Suicide or Suicide Attempt in the "Mortality and SEN Review" SharePoint folder.

✓ Files all relevant medical records and documents required for the mortality review in the "Mortality and SEN Review" SharePoint folder.

The Chief of MQMU, or designee:

✓ Notifies the AD, DAD/AS, MQMU CQI Program Manager, MQMU Risk Management Program Manager and Chief of MCMB (if applicable), that the 24 Hour Report of Natural Death, Suicide or Suicide Attempt is available for review in the "Mortality and SEN Review" SharePoint folder.

✓ If a psychological autopsy is required, notifies the selected behavioral health professional to initiate a psychological autopsy, and whether an on-site investigation is authorized.

All IHSC employees:

✓ Provide copies of all relevant documents and information that may aid the investigation to the CIU fact-finder.

- ✓ Provide copies of all documents and information requested by the CIU fact-finder.

c. Within 48 hours, or two business days, after the detainee's death (or when records are made available):

The CI fact-finder:

- ✓ Completes and submits a preliminary report of findings to the DAD/MD and Chief of MQMU.
- ✓ Files the preliminary report of findings in the "Mortality and SEN Review" SharePoint folder.

The Chief of MQMU, or designee:

- ✓ Notifies the DHS/OHA of the detainee's death, in accordance with DHS Instruction 248-01-001, Medical Quality Management.
- ✓ Notifies the AD, DAD/AS, MQMU CQI Program Manager, and MQMU Risk Management Program Manager and Chief of MCMU (if applicable), that the CI fact-finder's preliminary report is available for review in the "Mortality and SEN Review" SharePoint folder.

d. Within 30 business days of the detainee's death:

The DAD/MD, or designee:

- ✓ Ensures the mortality review is completed in accordance with the IHSC Clinical Incident Management Directive and Guide and guidance, and the instructions in this OM.

The behavioral health professional conducting the psychological autopsy:

- ✓ Submits the report to the DAD/MD, and CI fact-finder.
- ✓ Forwards all records and documents used to compile the report to the CI fact-finder, for filing in the mortality review case file.

The CI fact-finder:

- ✓ Coordinates the mortality review in accordance with the IHSC HSC Clinical Incident Management Directive and Guide and instructions in this OM.

- ✓ Prepares and routes the mortality review report in accordance with the HSC Clinical Incident Management Directive and Guide, and instructions in this OM.

- ✓ Routes the psychological autopsy report through the DAD/MD, editorial review, and AD for final approval.

- ✓ Once the mortality review is finalized, all documents and reports in the MQMU "Mortality and SEN Review" SharePoint folder are transferred to a designated folder in accordance with the current IHSC filing plan.

- ✓ Once the mortality review is finalized, access to the "Mortality and SEN Review" SharePoint folder is rescinded for all IHSC employees who were granted temporary access.

The IHSC Tasking Coordinator:

- ✓ Routes the mortality review report and psychological autopsy report for AD final approval and dissemination within IHSC in accordance with the IHSC Clinical Incident Management Directive and Guide

- ✓ Routes the mortality review report and psychological autopsy report to other DHS offices as directed by the AD.

- ✓ Routes all other reports and documents related to the mortality review as directed by the AD.

The Chief of MQMU, or designee:

- ✓ Ensures the mortality review is completed in accordance with the I HSC Clinical Incident Management Directive and Guide, and instructions in this OM.

- ✓ Submits a report to the DHS/OHA in accordance with DHS Instruction 248-01-001, Medical Quality Management.

2. Ongoing Requirements:

   a. The Chief of MQMU, or designee:

      Implements and tracks the recommendations made in the mortality review report in accordance with the HSC Clinical Incident Management Directive and Guide

Submits to the ICE Office of Detention Oversight (ODO) the mortality review report of findings and recommended actions, upon request.

b. The CI fact-finder:

If relevant information is received after the mortality review is completed, it is reported to the DAD/MD and Chief of MQMU.

G. Implementing and Monitoring Recommendations. For IHSC staffed facilities, the mortality review committee's recommended actions are implemented and monitored by the IHSC MQM Unit. For non-IHSC staffed facilities, the mortality review committee's recommended actions are implemented and monitored by ICE/ERO with support from the IHSC MQM and MCM Units.

APPLICABLE STANDARDS:

Applicable Accreditation Standards:

ICE Performance-Based National Detention Standards (PBNDS) 2008:
Medical Care, V.X.5. Health Care Internal Review and Quality Assurance
Terminal Illness, Advanced Directives, and Death, V.E.6.a (2) Medical Reports

ICE PBNDS 2011:

4.3.V.BB.2.e.(5) Health Care Internal Review and Quality Assurance

American Correctional Association (ACA) Performance-Based Standards for Adult Local Detention Facilities, 4th Edition:
4-ALDF-4D-24 Health Care Internal Review and Quality Assurance

ACA Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions, 1st Edition:
1-HC-4A-03 Internal Review and Quality Assurance

National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails:
J-A-10 Procedure in the Event of An Inmate Death

DHS References:

DHS Directive 248-01: Medical Quality Management (Revision 00)
DHS Instruction 248-01-001: Medical Quality Management (Revision 01)

ICE References:

11003.2: Notification and Reporting of Detainee Deaths